Today's Date:

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Name *(Last, First, M.I.):* ☐ M ☐ F ☐ Transgender	**DOB:**
Email address:	**Mobile phone :**
Previous or current pediatrician:	**How did you hear about us?:**
Current issue(s) of concern:	**Treatment goals:** 1) 2) 3)

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Healthy ☐ Frequent colds ☐ Ear infections ☐ Asthma ☐ Digestive issues ☐ ADD/ADHD ☐ Eczema ☐ Other:		
Vaccinations and dates:	☐Tetanus/Diphtheria/Pertussis	☐ Pneumonia	☐ Polio
	☐ Hepatitis B	☐ Shingles	☐ HPV (Gardasil)
	☐ Influenza (Flu)	☐ MMR *Measles, Mumps, Rubella*	☐ Hepatitis A
	☐ Chickenpox (Varicella)	☐ Prefer not to vaccinate	

List any medical problems that other medical provider have diagnosed and year of diagnosis

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Has your child ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List prescribed drugs, over-the-counter drugs, and any vitamins, supplements or inhalers (or attach current list)		
Name of Drug/Supplement (with strength)	Prescribed/Recommended by	Frequency Taken
Allergies to medications		
Name of Drug	Reaction You Had/Severity	

EXERCISE/ACTIVITY HISTORY

What sorts of exercise does your child engage in?

What does he/she most like to do for fun?

How much time does your child spend watching tv?

How much other screen time (phone, ipad, video games)?

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father	☐ Alive ☐ Deceased		**Children**	☐ M ☐ F	
Mother	☐ Alive ☐ Deceased			☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandfather** *Maternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandmother** *Paternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandfather** *Paternal*	☐ Alive ☐ Deceased	

OTHER PROBLEMS

Check if your child has, or has had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in: (see below)
☐ Head/Neck	☐ Back	☐ Weight
☐ Eyes/Ears	☐ Digestion	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowels	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

DIET

Please list foods typically consumed for the following meals

☐ Breakfast Time of meal:	☐ Lunch Time of meal:	☐ Dinner Time of meal:
Which of the following diets do you follow? Check all that apply: ☐ Omnivore (no restrictions) ☐ Vegetarian (eat eggs & milk products) ☐ Vegan (no eggs or milk products) ☐ Pescatarian (no meat other than fish) ☐ Gluten-free (no gluten) ☐ Paleo (minimal grains or dairy) ☐ FODMAPS (specific carb restriction) ☐ GAPS (gut & psychology syndrome) ☐ Other:	☐ Food sensitivities (list below with reaction):	☐ Snacks: ☐ Desserts:

BIRTH/OTHER HISTORY

Was child born vaginally or by c-section? (circle one) Birth weight: _____		
Complications:		
Genetic background: (circle all that apply) African European Native American Mediterranean Asian Ashkenazi Middle Eastern Prefer not to state		
Was child breast fed? If so, till what age:	☐ Yes	☐ No
Was child fed formula? Is so, what kind:	☐ Yes	☐ No
Has your child experienced any major life changes that may have impacted his/her health?	☐ Yes	☐ No
Is your child or family currently in therapy?	☐ Yes	☐ No
Does your child have a favorite toy or object?	☐ Yes	☐ No
Has your child ever been abused, a victim of a crime, or experienced a significant trauma?	☐ Yes	☐ No
Any sleeping troubles? Average number of hours your child sleeps per night: (circle one) >12 10-12 8-10 < 8	☐ Yes	☐ No
Who are the main people who care for your child?		